EQUITY AND ACCESS COUNCIL

Charter

This work group will develop for recommendation to the Healthcare Innovation Steering Committee a proposal for retrospective and concurrent analytic methods to ensure safety, access to providers and appropriate services, and to limit the risk of patient selection and under-service of requisite care; recommend a response to demonstrated patient selection and under-service; and define the state's plan to ensure that at-risk and underserved populations benefit from the proposed reforms. The Council will identify key stakeholder groups whose input is essential to various aspects of the Council's work and formulate a plan for engaging these groups to provide for necessary input. The Council will convene ad hoc design teams to resolve technical issues that arise in its work. Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. Under-service refers to systematic or repeated failure of a provider to offer [evidence-based] medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. A finding of failure shall not require proof of intentionality or a plan.

Key questions this work group needs to answer – Phase I – Design & Implementation

Setting Context

1. Equity includes assurance that underserved populations aren't subjected to targeted under-service and patient selection. Disparities in quality, outcomes, and care experience will be within the scope of the Quality Council.

Assessing Risk

1. What evidence is available today regarding patient selection and under-service in total cost of care payment arrangements (e.g. ACO, shared savings plan)?
2. Have public or private payers undertaken studies to examine the risk of patient selection or under-service that could inform this council's work?

Guarding against under-service

1. What are the current methods utilized by private and public payers for detecting under-service?
2. Can standard measures and metrics be applied for the detection of under-service?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect under-service?
4. Who will monitor, investigate, and report suspected under-service and what steps should be taken if under-service is suspected?
5. What are the criteria and processes that a payer might use to disqualify a clinician from receipt of shared savings due to demonstrated under-service?
6. What are the mechanisms for consumer complaints of suspected under-service?
7. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to under-service?

Guarding against patient selection

1. What are the current methods utilized by private and public payers for monitoring of patient selection?
2. Can standard measures and metrics be applied for the monitoring of patient selection?
3. What are the program integrity methods in use today by Medicare / Medicaid and how might such methods be applied to detect patient selection?
4. What other methods might be available to monitor for patient selection (e.g., mystery shopper)?
5. Who will monitor, investigate, and report suspected patient selection and what steps should be taken if patient selection is suspected?
6. What are the criteria and processes that a payer might use to disqualify a clinician from shared savings arrangements due to patient selection?
7. What are the mechanisms for consumer complaints of suspected patient selection?
8. Given the above, what is the Council's recommended approach for Connecticut's public and private payers to monitor for and respond to patient selection?

Questions this work group may opt to consider – Phase II

1. Network adequacy, provider participation, Medicaid specialty care, timely and necessary services?
2. Care variations and standardization, evidence-based standards?